STATE OF MICHIGAN

DEPARTMENT OF LICENSING & REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120587-001**

United Healthcare Insurance Company
Respondent

Issued and entered
this 22nd day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. BACKGROUND

On April 13, 2011, XXXXX (Petitioner) filed with the Commissioner of Financial and Insurance Regulation a request for external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified United Healthcare Insurance Company (UHC) of the external review request and requested the information it used to make its final adverse determination. On April 18, 2011, UHC furnished the requested information. After a preliminary review of the material submitted, the Commissioner accepted the request on April 20, 2011.

The issue here can be decided by analyzing the terms of the Petitioner's coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner has group health care coverage that is underwritten by UHC. Her benefits are defined in the UHC *Choice Plus* certificate of coverage (the certificate). According to the certificate's schedule of benefits, services from network providers are paid 100% after the network deductible ($250.00 individual/$500.00 family) has been met. Services from non-

network providers are paid at 70% after the non-network deductible ($500.00 individual/ $1,000.00 family) has been met.

In May 2009 the Petitioner was diagnosed with breast cancer. On June 24, 2009, she had a left breast mastectomy followed by chemotherapy and radiation treatment. The Petitioner subsequently had surgeries related to breast reconstruction on four dates: April 19, June 30, August 20, and October 29, 2010.[1] Each of these procedures was performed by XXXXX, MD.

UHC processed the claims for Dr. XXXXX's professional services on the four dates as non-network benefits. The Petitioner appealed, believing they should have been treated as network benefits. At the conclusion of its internal grievance process, UHC issued a final adverse determination dated March 1, 2011, upholding its original denial.

III. ISSUE

Did UHC correctly process the Petitioner's post-mastectomy claims?

IV. ANALYSIS

Before undergoing the mastectomy, the Petitioner states she contacted UHC to determine if Dr. XXXXX was an in-network provider. In an undated document that was submitted along with her request for external review, the Petitioner wrote:

> On June 4, 2009 I called UHC to inquire if Dr. XXXXX, MD was in-network. I spoke with XXXXX (verification code #B207424) he informed me that the doctor was in-network. With that information I chose Dr. XXXXX to perform the reconstruction of my left breast after mastectomy surgery on June 24, 2009. . . .
>
> * * *
>
> On June 4, 2009 I did my due diligence and called UHC to make sure all of the Doctors on my team were in network. UHC verified that Dr. XXXXX was in-network and should be treated that way for anything to do with my breast cancer. This is very upsetting during a time when I should be recovering and I did follow the proper procedure to make sure I was using in-network doctors.

After her inquiry, the Petitioner received services from Dr. XXXXX on June 4 and June 24, 2009. UHC processed those claims as network services, advising the Petitioner in an explanation of benefits statement dated October 2, 2009: "Thank you for using a network

1 The Petitioner had services on other dates but those claims were processed (or reprocessed) as network claims.

physician or other health care professional." However, after the Petitioner received additional services from Dr. XXXXX from April 19 to October 29, 2010, UHC decided that he was not a network provider. In its final adverse determination letter to the Petitioner dated March 1, 2011, UHC stated:

> According to your Benefit Plan, section entitled Schedule of Benefits, covered healthcare services received from a non-network provider are payable at 70% of eligible expenses after satisfying the annual non-network deductible.
>
> Because the claim(s) for this service(s) was processed according to the above plan provision(s), our original determination remains unchanged, and the determination is upheld. Our decision does not reflect any view about the medical appropriateness of this service(s). Only you and your physician can make decision about your medical care.
>
> You stated that in 2009; you verified that your provider was a participating provider in UnitedHealthcare's extensive network of physicians and other health care professionals. Each day, UnitedHealthcare actively solicits physicians and health care professionals to join its comprehensive network; however, enrollment is voluntary. As such, network membership is constantly changing, as providers' status changes.
>
> Because of these changes, we suggest that before receiving services, members always verify their provider's network status by calling the Customer Service phone number on the back of their insurance ID care, and confirm status with their provider.
>
> Please note that UnitedHealthcare processes claims as they are submitted by the provider of the service(s). We are unable to tell the provider how to bill for the service(s) received or change the way a claim(s) is submitted. We verified that the provider [*Dr. XXXXX*] is a participating provider under a separate tax identification number. In order for the claims to be reprocessed at your network level of benefits UnitedHealthcare would have to receive corrected claims from the provider with the network tax identification number submitted.
>
> We verified that UnitedHealthcare's Care Coordination department approved a network gap for date of service(s) August 20, 2010. We therefore have reprocessed this date of service(s) at your network level of benefits.

The Commissioner notes that UHC does not refute the Petitioner's contention that she called to confirm Dr. XXXXX's network status and was told that he was a network provider. It is undisputed that the Petitioner did precisely what UHC states she should have done: called to verify her provider's status.

The final adverse determination further supports the Petitioner's claim that she was advised that Dr. XXXXX was in UHC's network. UHC acknowledges that Dr. XXXXX *is* a participating provider, albeit with two tax identification numbers. It is difficult for the Commissioner to understand why UHC would expect the Petitioner to understand that a provider's network status would turn on a tax identification number. The Petitioner explained that she tried to respond to UHC's information about Dr. XXXXX's tax identification number:

> On July 15, 2009 I called United Health Care again to inquire as to why the Office visit of 6/4/09 and the surgery of 6/24/09 was being applied to deductibles "out of network". I spoke with XXXXX (verification code #B91961537478749) and he instructed me to call Dr. XXXXX's office for a different tax I.D. no. for billing purposes. Dr. XXXXX is covered in network at one address and not the other. Dr. XXXXX's office informed me that they did in fact bill under the correct tax I.D. no.

Notes from the Petitioner's formal second level appeal in UHC's internal grievance process reflect the ambiguity regarding Dr. XXXXX's networks status. The notes indicate:

> Appeal Issue: Member is appealing for network benefits for the services she received from 04/19/10-10/29/10. Member states she contacted UnitedHealthcare and was informed that XXXXX, M.D., was participating with her health plan.
>
> Upon initial review I show that XXXXX, M.D., is a network provider with the member's health plan under tax identification number XXXXX however the provider billed tax identification number XXXXX which is not participating with the member's health plan.

Based on the foregoing, the Commissioner concludes that the Petitioner was informed by UHC that Dr. XXXXX was a network provider. Since UHC does not dispute the medical necessity for Dr. XXXXX's care, the Commissioner finds that UHC must process the Petitioner's claims for service on April 19, June 30, August 20, and October 29, 2010, as though they were network benefits.

V. ORDER

The Commissioner reverses United Healthcare Insurance Company's final adverse determination of March 1, 2011. UHC shall cover the Petitioner's services of April 19, June 30, August 20, and October 29, 2010, at the network level, subject to the terms and conditions of the certificate within 60 days this Order and shall, within seven (7) days of providing coverage, furnish the Commissioner with proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding its implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner